ALCOHOL & DRUG ABUSE PREVENTION & TREATMENT (ADAPT) PROGRAM
THIS DATA IS SUBJECT TO THE PRIVACY ACT OF 1974 AS REVISED IN 1976

ADAPT QUESTIONNAIRE

Please fill in the information below. **Leave questions blank that do not apply to you.** Please answer each question openly and honestly so we may provide you with the most appropriate medical care possible. Please let a staff member know if you have questions at any time.

INCIDENT/REFERRAL:		
Name:		
Did you feel intoxicated/impaired at the time the incident occurred?		
Explain:		
What substance did you use:	How much:	Over how many hours:
Was a blood alcohol test, breathalyzer and/or urine sample taken?		Result:
Are there pending legal/administrative issues?		
SUBSTANCE USE HISTORY: (alcohol, marijuana, etc.)		
How old were you when you began to drink/use regularly?		
At this time, how often did you drink/use?		
About how much would you drink on an average occasion during this time?		
Has your pattern (frequency, amount) changed since you started drinking?		
What was the most you ever consumed in one sitting?		
When?	What was the occasion?	
Have you ever gotten sick from drinking too much?		
Have you ever passed out after drinking too much?		
Have you had occasions where you could not remember what happened while you were drinking?		
As a result of substance use, have you ever:		
missed work or class?		
had trouble at work or school including impaired attendance or poor performance?		
had arguments with friends or family?		
spent less time with family or friends?		
had a relationship break up, lost a friend?		
gotten into physical fights?		
given up hobbies and other interests?		
Have you ever drank/used and then did something that could be physically dangerous to yourself or others, i.e. driving under the influence?		
Were you ever stopped and/or arrested for driving under the influence, disorderly conduct, underage drinking, etc.?		
How many times?	When?	
Have you intentionally stopped drinking in the past?		
If so, did any of the following occur when you cut down or quit drinking/using?		
heart racing or sweating		
shaking, trembling		
sleep problems		
nausea or vomiting		
seeing, hearing, or feeling things that weren't really there		

feeling anxious, nervous, restless, or agitated
seizures
If so, how soon after you quit or cut down did the symptom(s) begin?
Have you ever taken something to stop withdrawal symptoms or to prevent them (e.g., drink to relieve withdrawal symptoms)
Has drinking/using caused physical injuries/problems?
Has drinking/using caused anxiety, depression, suicidal thoughts or attempts?
When drinking or using drugs, does your demeanor or personality change? How?
Have you ever been involved with a self-help group? (e.g., AA, NA)
Have you ever been referred or treated for your alcohol/drug use?
If so, was this helpful? Why?
PRESENT SUBSTANCE USE (IN THE PAST 12 MONTHS)
What is your present substance of choice (beer, wine, liquor, etc.)?
Who do you usually drink/use with? Where?
Reason you currently choose to drink:
How much does it take to feel the effects?
Currently, does it take more alcohol to feel the effects, compared to when you started drinking?
Describe in your words, what it is to be drunk:
How often do you get to the point of impairment or feeling intoxicated?
Has your overall substance use increased or decreased?
How much do you spend monthly on alcohol or drugs?
Date of last use?
Is your substance use currently impacting any of the following areas?
Job Performance
Social Life
Finances
Physical/emotional health
Relationships with family/friends
How would you describe your present emotional disposition:
Who do you rely on for emotional support?
Describe current life stressors:
Do stressors contribute to substance use:
Do you believe you have a substance abuse problem?
Do you want help for your substance use (education, counseling, etc)?
Have you attempted to cut down your alcohol intake?
Have you gotten angry when people approached you about your drinking habits?
Do you ever feel guilty after drinking?
Have you ever drank within hours after waking up?

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Alcohol Use Disorders Identification Test (AUDIT)

Please circle the answer that is correct for you

1. How often do you have a drink containing alcohol?

a. Never **b.** Monthly or less **c.** 2-4 times per month **d.** 2-3 times per week **e.** 4 or more times per week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

a. 1 or 2 **b.** 3 or 4 **c.** 5 or 6 **d.** 7 to 9 **e.** 10 or more

PLEASE ANSWER THE NEXT SIX QUESTIONS USING THE FOLLOWING KEY:

A. Never **B.** Less than monthly **C.** Monthly **D.** 2 - 3 times weekly **E.** 4 or more times weekly

3. How often do you have six or more drinks on one occasion? _____

4. How often during the last year have you found that you were not able to stop drinking once you had started? _____

5. How often during the last year have you failed to do what was normally expected from you because of drinking? _____

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? _____

7. How often during the last year have you had a feeling of guilt or remorse after drinking? _____

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? _____

9. Have you or someone else been injured as a result of your drinking?

Never	Yes, but not in the last year	Yes, during the last year

10. Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?

Never	Yes, but not in the last year	Yes, during the last year

Staff Use Only: TOTAL _____

Signature: Date:

Social Security Number: